FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016618

Facility Name: Mid America Care Center

Address: 4920 North Kenmore Ave (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 769-2700 **Fax #** (773) 769-3226

HFS ID Number: 201886154

Date of Initial License for Current Owners: 00/00/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds None

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	310	Skilled (SNF)	310	113,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	310	TOTALS	310	113,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	97,801	310	4,517	102,628	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	97,801	310	4,517	102,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 310 and days of care provided 3,536

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	331,494	91,969	11,690	435,153		435,153		435,153			1
2	Food Purchase		453,807		453,807	(41,084)	412,723	(2,174)	410,549			2
3	Housekeeping	359,480	103,491		462,971		462,971	2,361	465,332			3
4	Laundry	162,543	14,466		177,009		177,009		177,009			4
5	Heat and Other Utilities			225,309	225,309		225,309	5,473	230,782			5
6	Maintenance	194,118	43,642	72,375	310,135		310,135	10,339	320,474			6
7	Other (specify):*											7
8	TOTAL General Services	1,047,635	707,375	309,374	2,064,384	(41,084)	2,023,300	15,999	2,039,299			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	2,688,315	139,181	306,048	3,133,544		3,133,544		3,133,544			10
10a	Therapy	255,951		19,403	275,354		275,354		275,354			10a
11	Activities	194,504	19,054	1,183	214,741		214,741		214,741			11
12	Social Services	173,303			173,303		173,303		173,303			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,312,073	158,235	340,134	3,810,442		3,810,442		3,810,442			16
	C. General Administration											
17	Administrative	270,052		111,000	381,052		381,052	27,619	408,671			17
18	Directors Fees											18
19	Professional Services			551,237	551,237		551,237	(463,042)	88,195			19
20	Dues, Fees, Subscriptions & Promotions			97,719	97,719		97,719	(60,419)	37,300			20
21	Clerical & General Office Expenses	198,283	44,550	385,878	628,711		628,711	(248,571)	380,140			21
22	Employee Benefits & Payroll Taxes			828,578	828,578	41,084	869,662		869,662			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,569	4,569		4,569	450	5,019			24
25	Other Admin. Staff Transportation			4,135	4,135		4,135	90	4,225			25
26	Insurance-Prop.Liab.Malpractice			321,567	321,567		321,567	1,783	323,350			26
27	Other (specify):*							81,230	81,230			27
28	TOTAL General Administration	468,335	44,550	2,304,683	2,817,568	41,084	2,858,652	(660,860)	2,197,792			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,828,043	910,160	2,954,191	8,692,394		8,692,394	(644,861)	8,047,533			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mid America Care Center #0016618 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			76,634	76,634		76,634	82,022	158,656			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			244,698	244,698		244,698	(197,649)	47,049			32
33	Real Estate Taxes			371,515	371,515		371,515	(1,361)	370,154			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,743	7,743		7,743	(7,743)				35
36	Other (specify):*											36
37	**TOTAL Ownership**			700,590	700,590		700,590	(124,731)	575,859			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,347	354,653	458,000		458,000		458,000			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,725	169,725		169,725		169,725			42
43	Other (specify):*	218,861			218,861		218,861	(218,861)				43
44	**TOTAL Special Cost Centers**	218,861	103,347	524,378	846,586		846,586	(218,861)	627,725			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,046,904	1,013,507	4,179,159	10,239,570		10,239,570	(988,453)	9,251,117			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	70,647	30		9
10	Interest and Other Investment Income	(203,582)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30)	21		18
19	Entertainment				19
20	Contributions	(17,203)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(345,236)	21		24
25	Fund Raising, Advertising and Promotional	(43,146)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(318,144)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (856,708)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(131,745)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (131,745)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (988,453)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Mid America Care Center

ID# 0016618

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (2,160)	02	1
2	Misc. Income	(86)	21	2
3	Penalty	(30)	21	3
4	Theft & Loss	(347)	21	4
5	Marketing Salaries	(218,861)	43	5
6	Annual Fees - Rel Party	(408)	20	6
7	Adjustment of Prior Period Expense	(9,439)	21	7
8	Replacement Tax - Bldg	(3,415)	21	8
9	COPE	(3,974)	20	9
10	Legal Fees - Unallowable	(3,016)	19	10
11	Annual Fee	(250)	21	11
12	Non-Allowable Expense	(61,124)	21	12
13	Non Allowable R/E Prior Year	(5,731)	33	13
14	4930 - Utilities	(617)	05	14
15	4930 - Repairs & Maintenance	(951)	06	15
16	Auto Lease	(7,743)	35	16
17				17
18				18
19				19
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98				98
99				99
100				100
101	**Total**	(318,144)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mid America Care Center # 0016618 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2,174)											(2,174)	2
3	Housekeeping			1,538	823								2,361	3
4	Laundry													4
5	Heat and Other Utilities	(617)		2,663	3,427								5,473	5
6	Maintenance	(951)		8,360	2,930								10,339	6
7	Other (specify):*													7
8	**TOTAL General Services**	(3,742)		12,561	7,180								15,999	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			116,307	1,159	(89,847)							27,619	17
18	Directors Fees													18
19	Professional Services	(3,016)		(461,862)	778	1,058							(463,042)	19
20	Fees, Subscriptions & Promotions	(64,723)		4,182	7	115							(60,419)	20
21	Clerical & General Office Expenses	(419,957)		170,883	156	347							(248,571)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			450									450	24
25	Other Admin. Staff Transportation			90									90	25
26	Insurance-Prop.Liab.Malpractice			1,464	319								1,783	26
27	Other (specify):*			79,612		1,618							81,230	27
28	**TOTAL General Administration**	(487,696)		(88,874)	2,419	(86,709)							(660,860)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(491,438)		(76,313)	9,599	(86,709)							(644,861)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Mid America Care Center **#** 0016618 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	70,647		10,694	514	167							82,022	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(203,582)		919	5,014								(197,649)	32
33	Real Estate Taxes	(5,731)			4,370								(1,361)	33
34	Rent-Facility & Grounds			22,451	(22,451)									34
35	Rent-Equipment & Vehicles	(7,743)											(7,743)	35
36	Other (specify):*													36
37	TOTAL Ownership	(146,409)		34,064	(12,553)	167							(124,731)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(218,861)											(218,861)	43
44	TOTAL Special Cost Centers	(218,861)											(218,861)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(856,708)		(42,249)	(2,954)	(86,542)							(988,453)	45

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 1,538	$ 1,538	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,663	2,663	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	8,360	8,360	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	116,307	116,307	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	766	766	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	4,182	4,182	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	170,883	170,883	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	450	450	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	90	90	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	1,464	1,464	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	79,612	79,612	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	10,694	10,694	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	919	919	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	22,451	22,451	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%			30
31	V	19	HOME OFFICE	462,628	MANAGCARE, INC.	100.00%		(462,628)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 462,628			$ 420,379	$ * (42,249)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MAZEL MANAGEMENT	100.00%	$ 823	$ 823	15
16	V	5	UTILITIES		MAZEL MANAGEMENT		3,427	3,427	16
17	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		2,930	2,930	17
18	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		1,159	1,159	19
20	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		778	778	20
21	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		7	7	21
22	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		156	156	22
23	V	26	INSURANCE		MAZEL MANAGEMENT		319	319	23
24	V	30	DEPRECIATION		MAZEL MANAGEMENT		514	514	24
25	V	31	AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		5,014	5,014	26
27	V	33	REAL ESTATE TAXES				4,370	4,370	27
28	V								28
29	V	34	RENT	22,451				(22,451)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,451			$ 19,497	$ * (2,954)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 21,153	$ 21,153	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,058	1,058	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	115	115	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	347	347	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,618	1,618	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	167	167	20
21	V								21
22	V	17	MANAGEMENT FEES	111,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(111,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 111,000			$ 24,458	$ * (86,542)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Shareholder	Relative	54.08%	See Attached	25.38	42.30%	Intercare,Sal	$ 36,153	17-1, 17-7	1
2	Moshe Davis	Operation Dir	Administrative	0.56%	See Attached	6.85	12.23%	Salary	45,371	17-1	2
3	Yehoshua Davis	Director	Administrative	0.56%	See Attached	39.85	71.16%	Salary	123,509	17-1	3
4	Shoshana Braun	Clinical Support	Nursing Clerical	0.56%	See Attached	1.79	38.74%	Salary	1,125	10-1	4
5	Chasida Davis	Bookkeeper	Clerical	0.00%	See Attached	8.75	43.75%	Managcare	7,838	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 213,996		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	234,501	5	$ 3,513	$	102,628	$ 1,538	1
2	5	UTILITIES	PATIENT DAYS	234,501	5	6,086		102,628	2,663	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	234,501	5	19,103		102,628	8,360	3
4	10	NURSING SALARIES	PATIENT DAYS	234,501	5			102,628		4
5	17	ADMINISTRATIVE	PATIENT DAYS	234,501	5	265,757	265,757	102,628	116,307	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	234,501	5	1,750		102,628	766	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	234,501	5	9,556		102,628	4,182	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	234,501	5	390,462	341,991	102,628	170,883	8
9	24	SEMINARS	PATIENT DAYS	234,501	5	1,028		102,628	450	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	234,501	5	205		102,628	90	10
11	26	INSURANCE	PATIENT DAYS	234,501	5	3,344		102,628	1,464	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	234,501	5	181,911		102,628	79,612	12
13	30	DEPRECIATION	PATIENT DAYS	234,501	5	24,435		102,628	10,694	13
14	32	INTEREST EXPENSE	PATIENT DAYS	234,501	5	2,099		102,628	919	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	234,501	5	51,300		102,628	22,451	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	234,501	5			102,628		16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 960,549	$ 607,748		$ 420,379	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	234,501	5	$ 1,881	$	102,628	$ 823	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	234,501	5	7,831		102,628	3,427	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	234,501	5	6,696		102,628	2,930	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	234,501	5			102,628		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	234,501	5	2,649		102,628	1,159	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	234,501	5	1,778		102,628	778	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	234,501	5	16		102,628	7	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	234,501	5	357		102,628	156	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	234,501	5	728		102,628	319	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	234,501	5	1,175		102,628	514	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	234,501	5			102,628		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	234,501	5	11,457		102,628	5,014	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	234,501	5	9,986		102,628	4,370	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 44,554	$		$ 19,497	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	7	$ 50,000	$ 50,000	25	$ 21,153	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	7	2,500		25	1,058	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	7	271		25	115	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	7	821		25	347	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	7	3,825		25	1,618	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	7	394		25	167	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 57,811	$ 50,000		$ 24,458	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Related Party Interest	X					$	$			$ 57,437	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				3,450,000			182,659	6
7	Interest Expense - Ins		X								4,369	7
8	See Supplemental Schedule							11,637			6,166	8
9	TOTAL Facility Related						$	$ 3,461,637			$ 250,631	9
	B. Non-Facility Related*											
10	Interest Income - Bldg.										(203,582)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (203,582)	14
15	TOTALS (line 9+line14)						$	$ 3,461,637			$ 47,049	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Automobile Loan		X				$	$ 11,637			$	8
9	Allocated From Managcare		X								919	9
10	Allocated From Mazel Mgmt		X								5,014	10
11	Interest - Brightview		X								233	11
12												12
13												13
14	TOTAL Working Capital							11,637			6,166	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mid America Care Center **#** 0016618 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	362,575	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	360,229	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,346)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	372,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	370,154	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	368,742	8
	2001	378,332	9
	2002	378,498	10
	2003	348,126	11
	2004	355,859	12

2005 Accrual $361560x1.03 = $372,500 (rounding)

Allocated From Mazel Management = $4,190

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016618

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-410-017-0000	4930 N. Kenmore	$ 5,730.00	$
2.	14-08-410-018-0000	4928 N. Kenmore	$ 98,696.29	$ 98,696.29
3.	14-08-410-019-0000	4922 N. Kenmore	$ 98,696.29	$ 98,696.29
4.	14-08-410-020-0000	4918 N. Kenmore	$ 98,696.29	$ 98,696.29
5.	14-08-410-021-0000	4912 N. Kenmore	$ 59,770.65	$ 59,770.65
6.	Allocated From Mazel Mgmt		$ 41,756.66	$ 4,189.68
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 403,346.18	$ 360,049.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016618

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,500 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,500	1979	$ 307,874	1
2					2
3	TOTALS	94,500		$ 307,874	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	2,575		20			2,575	9
10	Various			1979	33,995		20			33,995	10
11	Various			1980	13,673		20			13,673	11
12	Various			1981	107,932		20	4,205	4,205	107,237	12
13	Various			1982	4,750		20			4,750	13
14	Various			1983	1,787		20			1,787	14
15	Various			1984	25,291		20			25,042	15
16	Various			1985	17,828		20	32	32	17,680	16
17	Various			1986	62,698		20	522	522	61,208	17
18	Various			1987	18,422		20	501	501	15,522	18
19	Various			1988	33,825		20	1,353	1,353	23,979	19
20	Various			1989	23,916		20	525	525	20,896	20
21	Various			1990	23,550		20	1,178	1,178	18,269	21
22	Various			1991	20,020		20	429	429	9,463	22
23	Various			1992	51,260		20	2,563	2,563	34,345	23
24	Various			1993	7,134		20	357	357	4,707	24
25	Various			1994	32,273		20	1,613	1,613	18,177	25
26	Various			1995	227,831		20	11,521	11,521	121,297	26
27	Various			1996	136,732		20	6,837	6,837	65,439	27
28	Various			1997	26,804		20	1,340	1,340	11,443	28
29	Various			1998	81,506		20	4,077	4,077	30,385	29
30	Various			1999	113,499		20	5,676	5,676	37,029	30
31	Various			2000	308,605		20	15,599	15,599	85,824	31
32	Various			2001	56,517		20	2,827	2,827	12,762	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,258,613					3,258,613	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		117,246	1,961		5,073	3,112	92,635	68
69	Financial Statement Depreciation			15,669			(15,669)		69
70	TOTAL (lines 4 thru 69)		$ 4,808,282	$ 17,630		$ 66,228	$ 48,598	$ 4,128,732	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,808,282	$ 17,630		$ 66,228	$ 48,598	$ 4,128,732	1
2	Install Ceramic Tile	2002	4,000		20	400	400	1,567	2
3	Flooring	2002	1,818		20	182	182	727	3
4	Carpentry Work	2002	2,700		20	270	270	1,035	4
5	Flooring	2002	1,407		20	141	141	551	5
6	Carpentry Work	2002	4,420		20	442	442	1,584	6
7	Flooring	2002	1,786		20	179	179	685	7
8	Carpentry	2002	9,318		20	932	932	3,494	8
9	Carpentry	2002	2,620		20	262	262	983	9
10	Floor Tile	2002	5,809		20	581	581	2,178	10
11	Monitoring Cameras	2002	1,556		20	311	311	1,115	11
12	A/C	2002	9,960		20	1,992	1,992	7,470	12
13	A/C Circuits	2002	3,686		20	737	737	2,519	13
14	Doors	2002	613		20	61	61	189	14
15	Doors	2002	613		20	61	61	194	15
16	Elevator	2002	4,180		20	209	209	644	16
17	Fence	2002	2,207		20	147	147	539	17
18	Fence Installation	2002	2,207		20	110	110	414	18
19	Electrical	2002	1,173		20	59	59	210	19
20	Fan Blade	2002	1,824		20	91	91	304	20
21	Door Transmitter	2002	2,180		20	109	109	354	21
22	Door Screens	2002	1,210		20	61	61	197	22
23	Elevator Repairs	2002	1,540		20	77	77	263	23
24	Control Panel	2003	2,810		20	281	281	843	24
25	Annuciator Panel	2003	3,105		20	311	311	802	25
26	Elevator Key Pad	2003	1,092		20	55	55	164	26
27	Water Heater	2003	6,650		20	554	554	1,616	27
28	Smoke Dampers	2003	2,380		20	238	238	674	28
29	Air Handler	2003	3,975		20	398	398	828	29
30	Fire Alarm	2003	4,081		20	408	408	850	30
31	Elevator Flooring	2003	1,185		20	59	59	173	31
32	Fire Alarm Duct	2003	930		20	47	47	140	32
33	Fire Alarm Repair	2003	618		20	31	31	90	33
34	TOTAL (lines 1 thru 33)		$ 4,901,935	$ 17,630		$ 76,024	$ 58,394	$ 4,162,128	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,901,935	$ 17,630		$ 76,024	$ 58,394	$ 4,162,128	1
2	Air Filter Motor	2003	1,403		20	70	70	205	2
3	Door Locking System	2003	699		20	35	35	102	3
4	Fire Dampers	2003	1,016		20	51	51	148	4
5	Smoke Dampers	2003	519		20	26	26	78	5
6	Evaporator Fan Motor	2003	591		20	30	30	76	6
7	Latching Alarm System	2003	697		20	35	35	87	7
8	Alarm Bell	2003	602		20	30	30	70	8
9	Fire Alarm Repair	2003	720		20	36	36	75	9
10	Awning	2004	2,307		20	231	231	250	10
11	Carpeting	2004	1,357		20	194	194	226	11
12	Digital Keypad	2004	1,379		20	138	138	149	12
13	Walk In Freezer Repair	2004	615		20	36	36	36	13
14	Nurses Station Electrical	2004	1,302		20	81	81	81	14
15	Door Locking System	2004	847		20	60	60	60	15
16	Repair Exterior Door	2004	543		20	38	38	38	16
17	Door Locking System	2004	757		20	60	60	60	17
18	Generator Maintenance	2004	850		20	64	64	64	18
19	Chiller System Repair	2004	565		20	42	42	42	19
20	Elevator Repair	2004	529		20	42	42	42	20
21	Elevator Repair	2004	545		20	45	45	45	21
22	Monitoring System Repair	2004	1,141		20	105	105	105	22
23	Lock Down System	2005	1,395		20	70	70	70	23
24	Door Wreck Work	2005	2,200		20	37	37	37	24
25	Call System 6Th Flt	2005	9,632		20	80	80	80	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,146	$ 17,630		$ 77,660	$ 60,030	$ 4,164,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1971	$ 3,258,613	$		$	$	$ 3,258,613	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,258,613	$		$	$	$ 3,258,613	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated From Mazel Management		1985	1985	$ 45,151	$	30	$ 1,505	$ 1,505	$ 30,477	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Managcare			1997	5,264	-	20	526	526	4,430	9
10	Allocated from Managcare			1993	413	-	20	21	21	259	10
11	Allocated fromManagcare			1988	644	20	20	32	12	553	11
12	Allocated from Managcare			1986	48,829	1,261	20	2,236	(975)	47,344	12
13											13
14	Allocated from Mazel Management			2005	1,065	152	20	51	(101)	51	14
15	Allocated From Mazel Management			2001	948	24	20	47	23	213	15
16	Allocated From Mazel Management			2000	479	12	20	24	12	126	16
17	Allocated From Mazel Management			1998	1,689	58	20	85	27	651	17
18	Allocated From Mazel Management			1997	1,575	40	20	79	39	656	18
19	Allocated From Mazel Management			1996	1,074	12	20	54	42	514	19
20	Allocated From Mazel Management			1995	243	6	20	12	6	129	20
21	Allocated From Mazel Management			1994	959	18	20	48	30	501	21
22	Allocated From Mazel Management			1993	566	16	20	28	12	352	22
23	Allocated From Mazel Management			1991	424	13	20	21	8	290	23
24	Allocated From Mazel Management			1990	659	14	20	33	19	506	24
25	Allocated From Mazel Management			1989	412	10	20	17	7	287	25
26	Allocated From Mazel Management			1987	937	18	20	-	(18)	937	26
27	Allocated From Mazel Management			1986	3,785	120	20	161	41	3,691	27
28	Allocated From Mazel Management			1985	263	-	120	-		263	28
29											29
30	Allocated From Intercare, Ltd.			2001	1,867	167	20	93	(74)	405	30
31											31
32											32
33											33
34											34
35											35
36											36

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 117,246	$ 1,961		$ 5,073	$ 1,162	$ 92,635	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 681,438	$ 56,949	$ 60,515	$ 3,566	10	$ 349,860	71
72	Current Year Purchases	16,505	2,528	1,238	(1,290)	10	1,238	72
73	Fully Depreciated Assets	722,781				10	722,684	73
74								74
75	TOTALS	$ 1,420,724	$ 59,477	$ 61,753	$ 2,276		$ 1,073,782	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		MITSUBISHI	2003	$ 22,522	$ 4,020	$ 4,020	$	5	$ 13,142	76
77		Allocated from Managcare	2005	87,275	6,882	15,223	8,341	5	40,384	77
78										78
79										79
80	TOTALS			$ 109,797	$ 10,902	$ 19,243	$ 8,341		$ 53,526	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,772,541	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,009	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,656	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 70,647	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,291,662	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1994 ALTIMA - 1994	$ 17,799	$	$ 17,799	86
87	4930 BLDG - 1998	159,035	7,952	62,290	87
88	4930 LAND - 1998	17,500			88
89					89
90					90
91	TOTALS	$ 194,334	$ 7,952	$ 80,089	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 100,454	$		$ 100,454	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,780			13,780	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			101,315			101,315	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			133,539			133,539	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 03				4,172	4,949		9,121	12
13	Other (specify): See Supplemental					1,393	98,398		99,791	13
14	TOTAL			$		$ 354,653	$ 103,347		$ 458,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center **#** 0016618 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 115,275	$	1
2	Cash-Patient Deposits	6,813		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,940,611		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	304,525		6
7	Other Prepaid Expenses	20,888		7
8	Accounts Receivable (owners or related parties)	3,296,483		8
9	Other(specify): See Attached Schedule	146,612		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,831,207	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	325,318		13
14	Buildings, at Historical Cost	3,417,648		14
15	Leasehold Improvements, at Historical Cost	1,488,964		15
16	Equipment, at Historical Cost	1,294,315		16
17	Accumulated Depreciation (book methods)	(5,183,164)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	12,006		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,355,087	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,186,294	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 372,410	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,541		28
29	Short-Term Notes Payable	11,637		29
30	Accrued Salaries Payable	191,666		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,181		31
32	Accrued Real Estate Taxes(Sch.IX-B)	372,500		32
33	Accrued Interest Payable	12,342		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	79,445		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,138,722	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,450,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,450,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,588,722	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,597,572	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,186,294	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,628,867	1
2	Restatements (describe):		2
3	Depreciation Expense	84,351	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,713,218	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,834,354	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(950,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 884,354	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,597,572	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,656,974	1
2	Discounts and Allowances for all Levels	(474,716)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,182,258	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	460,333	6
7	Oxygen	72	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 460,405	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	145,155	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,116	19
20	Radiology and X-Ray	1,245	20
21	Other Medical Services	27,683	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 184,199	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	203,582	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 203,582	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	43,480	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,480	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,073,924	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,064,384	31
32	Health Care	3,810,442	32
33	General Administration	2,817,568	33
	B. Capital Expense		
34	Ownership	700,590	34
	C. Ancillary Expense		
35	Special Cost Centers	676,861	35
36	Provider Participation Fee	169,725	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,239,570	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,834,354	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,834,354	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	824	952	$ 33,092	$ 34.76	1
2	Assistant Director of Nursing	2,162	2,435	60,034	24.65	2
3	Registered Nurses	26,552	28,144	706,897	25.12	3
4	Licensed Practical Nurses	24,309	26,379	517,511	19.62	4
5	CNAs & Orderlies	121,405	132,526	1,316,172	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,522	18,616	255,951	13.75	8
9	Activity Director	2,032	2,240	45,498	20.31	9
10	Activity Assistants	17,315	18,509	149,006	8.05	10
11	Social Service Workers	12,648	13,809	173,303	12.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,928	33,535	331,494	9.89	15
16	Dishwashers					16
17	Maintenance Workers	12,846	15,262	194,118	12.72	17
18	Housekeepers	41,414	44,029	359,480	8.16	18
19	Laundry	16,854	18,297	162,543	8.88	19
20	Administrator	2,028	2,072	163,958	79.13	20
21	Assistant Administrator	2,200	2,486	85,248	34.29	21
22	Other Administrative	2,072	2,429	20,846	8.58	22
23	Office Manager					23
24	Clerical	9,109	9,940	198,283	19.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,008	4,384	54,609	12.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,376	6,376	218,861	34.33	33
34	TOTAL (lines 1 - 33)	351,604	382,420	$ 5,046,904 *	$ 13.20	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	268	$ 11,690	01-03	35
36	Medical Director	Monthly	13,500	09-03	36
37	Medical Records Consultant	2,662	3,168	10-03	37
38	Nurse Consultant	3,396	124,156	10-03	38
39	Pharmacist Consultant	3	150	10-03	39
40	Physical Therapy Consultant	184	9,740	10a-03	40
41	Occupational Therapy Consultant	171	8,881	10a-03	41
42	Respiratory Therapy Consultant	4	216	10a-03	42
43	Speech Therapy Consultant	11	566	10a-03	43
44	Activity Consultant	1,183	1,183	11-03	44
45	Social Service Consultant				45
46	Other(specify) Renal Therapy Con	648	32,349	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	8,530	$ 205,599		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	4,323	146,225	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,323	$ 146,225		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehoshua Davis	Administrator	.56%	$ 123,509
Michael Applebaum	Assistant Admin	0%	81,716
Linda Weiss	Assistant Admin	0%	4,456
Yosef Davis	Director	54.08%	15,000
Moshe Davis	Director	.56%	45,371
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 270,052

B. Administrative - Other

Description	Amount
Management Fees - Intercare	$ 111,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 111,000

C. Professional Services

Vendor/Payee	Type	Amount
Econocare, Inc.	Purchasing Consultant	$ 5,220
Personnel Planners	Unemployment Consultant	3,481
Managcare Inc.	Bookkeeping	462,628
FR&R	Accounting Fees	46,415
Professiona Fee - Bldg	Adjusted Out on Page 5	26,148
See Attached	Legal Fees	7,345
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 551,237

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,729
Unemployment Compensation Insurance	47,419
FICA Taxes	383,762
Employee Health Insurance	196,716
Employee Meals	41,084
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	3,977
Chicago Head Tax	8,944
Disability Insurance	7,002
Employee Pension	59,472
Employee Benefits	28,557
TOTAL (agree to Schedule V, line 22, col.8)	$ 869,662

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,574
Health Care Worker Background Check	814
(Indicate # of checks performed 9)	
Licenses & Permits	3,277
ILCLTC	14,318
Dues & Subscriptions	3,013
See Supplemental Schedule	4,304
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,300

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,569
Allocated From Managcare	450
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,019

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center **#** 0016618 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC $14,318**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **No**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,477** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **169,725**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **41,084** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.